Nursing Facility Provider Fee Advisory Board
October 17, 2014
Meeting Minutes

PRESENT	
Josh Fant	Matt Haynes - HCPF
Paul Landry	Cynthia Miley - HCPF
Arlene Miles	Jeff Witreich - HCPF
Lonnie Hilzer	Jennifer Reinheimer – Myers & Stauffer
Janet Snipes	Ashleigh Perez - Myers & Stauffer
Cindy Bunting - Phone	Josh Fant - CHCA
Chris Stenger - Phone	
Greg Traxler	
John Brammeier	
ABSENT	
Dan Stenerson	Lori Nelson

Approximate Time	Topic	Lead
10:00 – 10:05	❑ Welcome, Introductions, and Approval of Minutes	*Matt Haynes, HCPF*
10:05-10:35	❑ Independent Living	*Matt Haynes, HCPF*
10:35 – 11:00	❑ PASRR II and CPS	*Matt Haynes, HCPF*
11:00 – 11:10	❑ P4P Update	*CoHCA*
11:10 – 11:20	❑ NVC Update	*Randie Wilson, HCPF*
11:20 – 11:40	❑ OIG Audit A-07-14-04215	*Matt Haynes, HCPF*
11:40 – 11:45	❑ Open Discussion/Public Comment	*Matt Haynes, HCPF*
11:45	❑ Adjournment	

<u>The next meeting will be held:</u>

November 21, 2014
10:00 a.m. – 12:00 p.m.
225 E 16th Ave, Room 6 A/B
Denver, CO 80203

Meeting was called to order at 10:05 a.m.

Approval of Minutes:
The minutes from the August 22, 2014 meeting were approved as written.

Independent Living:
Matt Haynes

- Skilled nursing facilities , independent living, and assisted living are all requirements to qualify for CCRC
    - Don't have any guidance around independent living
- **Arlene Miles -** California provider fee program excludes continuing care facilities and CCRC type facilities
    - Facilities must apply to be excluded, the department decides
    - They have a whole criteria on what is considered independent living
- What is the intention of the exemption
- **John Brammeier -** Independent living must be more than two rooms
    - Is intended for those living on their own, nurses don't come in everyday
    - The space is just a lease, meant to be a stepping stone until they need to go into assisted living
- Always want to operate in good faith need to minimize risk with some type of standard
- Don't want to create something where someone is a qualified CCRC but don't meet the requirements because of the independent living standards
- Look at how best to make sure to make this fair and equitable
    - Need to make sure the system is not gamed
- **John Brammeier -** Do we grandfather in the folks that have already done it

PASRR II & CPS:
Matt Haynes

- The MDS is now capturing PASRR II
- We have a program that is a specialized behavioral services program for PASRR II residents
- We have a supplemental payment for residents to have PASRR II classification in their facility
    - This is now being captured in the acuity and reflected in the rate
    - Is there still a value for having this payment
    - Is that level of care best defined with PASRR II or are we missing some patients that need the same level of care but are not classified as PASRR II
- **Janet Snipes –** These are people that are very difficult to place, most of them are behavioral with mental health needs. We are capturing some of them but there are others that don't require additional help. Some with mental health needs do require additional care. Because they have low acuity, taking these residents can have a significant downward effect on the facility's Medicaid acuity.
- **Arlene Miles** – When you do an acuity assessment you are chasing the nurse and not the social worker.

- **Janet Snipes** – With the PASRR II we are capturing other costs
- Seems to be increase in cases of dementia, the cognitive issues are more evasive, behavioral services are becoming more in demand
- Do we want to incentivize behavioral services
- A lot that can be done through specialized training
- **Arlene Miles** – Restructure a piece of this plan and freed up more money to pay for that type of training.
- **Janet Snipes** – When you accept a PASRR II resident depending on their needs, they come with a plan that you train your staff in. Sometimes the mental health program comes in and trains the staff.
- **John Brammeier** – There is a need in our community at the hospital level that is not being met right now. We've lost the acute psychiatric services with nowhere to send them, we are serving a need but we need help. Need to have an acute hospital that has the ability to manage these individuals
- Instead of just paying for the PASRR II residents can we pay for the general specialized services training
- Those who are needing the resources are not always PASRR II
- Is it a type of patient that is not always captured by PASRR II are we able to identify those and make a payment around that
- Should we be incentivizing facilities that are caring for all these types of patients or does it make more sense to look at what types of training and environment we can create with the dollars
- **John Brammeier** – This year's calculations for the PASRR II we are not getting the number of active residents we have on hand
- **Paul Landry –** Maybe redesign the program and make payment more robust to incentivize providers to take these residents
- If these are all Medicaid residents then it will impact the providers acuity
- Want to make sure we are hitting the intention of what we want to do with CPS payments
- Want to make sure we are adaptive enough to stay current in the state of affairs
- Should we discuss going to RUG 4, CMS may eventually require that
- **Janet Snipes -** If we are capturing all this additionally information on the MDS why wouldn't we want to use this information
- This is the first year that we can transition all components of the rate to RUG 4
- **Janet Snipes –** It seems like a more accurate accounting of the residents

P4P Update:

CoHCA – Josh Fant & Janet Snipes

- In the quality of life domain what was originally 3 categories are now 2 categories
- Combined things to free up points for other things
- Committee tries to stay current with what CMS is doing and what the new initiatives are out there. We try to keep it fresh, CMS has new initiatives every year.
- Committee added indirect staff, felt indirect care staff is equally important as direct staff.

- Each drop in 5 percentile points you get 1 less point
- Not getting a point if you are not in the top half
- Committee felt that you should not get any points for being below the 50th percentile
- Added tracking of the quality measure composite score
- Nursing Staff turnover rate is new
    - Total staff retention has been measured for a few years
    - This measures just the nursing staff specifically

NVC Update:
Matt Haynes

- The appraisals have begun and the first batch should be done by November 1st, if you are submitting questions email: hcpf.snffrv@state.co.us
- Want to get list of criteria they use to make their judgments out to the facilities
- **Janet Snipes** – What we set up with Randie Wilson is not actually happening
    - They are supposed to get ahold of use to schedule appraisals and give us timeframes
    - They have been told the administrator and the plan operations supervisor need to be there
    - List of criteria is not out so many providers don't know what they need to have on hand for the appraisal
    - Explained our concerns about the matrix but did not have time to address them
- **John Brammeier** – Appreciate everything Randie Wilson did
    - The scheduling piece is very important, we need to make sure we have the right people there for the walkthroughs
- Scheduling is hit or miss, some are scheduled out into late October

OIG Audit:
Matt Haynes

- There was an audit conducted for FYs 09-10, 10-11, 11-12
- Some payments made through the COFRS system that didn't match the final models in 09-10 & 10-11
- We are not going to be adjusting a provider fee model or cash fund
- There may be some place where we have very minimal recoveries, letters will go out
- Nothing found for 11-12 because part of the corrective action plan we have already done

Board Recommendations

- There were no action items for this meeting

Public Comment

- There was no public comment

The meeting was adjourned at 11:40 a.m.